FEB 28 1935

STATISTICAL BULLETIN

METROPOLITAN LIFE INSURANCE COMPANY

VOLUME XV NOVEMBER · 1934 NUMBER 11

The Chances of Celebrating a Golden Wedding

THAT depends on one's age and that of the consort at the time of the marriage. Taking about an average case, in which the bride is 22 years old and the bridegroom 25, the chance that they will both survive to celebrate their golden wedding 50 years later is 168 in a 1,000, or just about one in six. Their chances of surviving to their silver wedding are, of course, very much greater; in fact, just about three in four; and their chance of reaching their tenth anniversary is not very far from certainty, namely, 927 per 1,000, or considerably in excess of nine in ten.

These figures will be found in the accompanying table, which gives a great deal of more detailed information from which couples of varying age at marriage can read off the probability that they will survive to their tenth, twenty-fifth and fiftieth wedding anniversary. If they are both very young, their chances of living to the time of their golden wedding are quite good. So, for example, if the bride is 18 and the bridegroom 23 (a combination of ages by no means uncommon), they stand a chance of almost one in four of surviving to their golden wedding, namely, as the table reads, 235 per 1,000. On the contrary, it stands to reason that the relatively infrequent cases of late marriage have only a very slim chance of celebrating their golden anniversary. So, for example, if the bride is 37 and the bridegroom 42 at the time of their marriage, they stand just about one chance in a thousand of surviving until the fiftieth anniversary day of their wedding.

The accompanying table requires little explanation. To list the chances for every possible combination of ages for bride and groom would evidently be out of the question within any reasonable compass. This is, however, hardly necessary, for it will usually be possible to gauge with sufficient accuracy the probabilities for combinations of ages lying between those actually shown in the table. For example, if the bride is 20 and the bridegroom 24, it will be seen that the chances of surviving to the golden wedding lie somewhere between 216 and 186 per 1,000 and it will be quite close enough to reckon that the figure half way between these two, namely, 201

chances per 1,000, correctly represents the required probability.

The figures quoted above, and those in the table, relate to chances of both parties to the marriage *surviving* to the several anniversaries. With the prevalence of divorce which is characteristic of modern times, mere survival to these anniversaries does not necessarily imply their celebration. The figures must be interpreted in this sense as giving the chances of *celebration* of the anniversary only for those couples who have persevered in the married state and have not become separated by divorce in the intervening years.

*Chances per 1,000 That a Newly Married Couple Will Survive Jointly to Their Tin, Silver and Golden Wedding Anniversaries**

Age of Bride	Chances per 1,000 of Joint Survival for Stated Number of Years											
	10	25	50	10	25	50	10	25	50	10	25	50
	Groom of same age			Groom 3 years older			Groom 5 years older			Groom 10 years older		
18	938	809	311	935	795	266	933	784	235	926	749	152
19	936	801	285	933	787	241	931	775	210	923	737	131
20	934	794	260	931	778	216	929	765	186	920	725	111
21	932	785	234	929	769	192	926	755	163	916	711	93
22	930	777	209	927	759	168	924	744	141	913	697	76
23	928	767	185	925	748	146	921	733	120	909	682	61
24	926	757	162	922	737	125	919	720	101	905	666	49
25	924	747	140	920	725	105	916	707	83	901	649	38
26	922	735	119	917	712	87	912	693	68	896	632	29
27	920	723	100	914	698	71	909	677	54	891	613	22
28	917	710	82	910	683	57	905	661	42	886	593	16
29	914	696	67	906	667	45	900	644	32	880	572	11
30	910	680	53	902	649	34	895	625	24	874	550	8
31	906	664	41	898	631	26	890	605	18	867	527	5
32	902	647	31	892	612	19	885	585	12	860	503	3
33	897	628	23	887	591	13	879	563	9	852	478	2
34	892	608	17	881	570	9	872	540	6	844	452	1
35	887	587	12	875	547	6	865	517	4	835	425	1
36	880	565	8	868	524	4	858	492	2	825	398	†
37	874	542	5	860	499	3	850	466	1	815	370	†
38	867	518	3	852	473	2	841	440	1	803	342	†
39	859	493	2	844	447	1	832	412	†	791	314	†
40	851	467	1	835	420	1	822	384	†	778	285	†
41	842	440	1	825	392	†	811	356	†	764	257	†
42	833	413	†	814	364	†	799	328	†	749	230	†
43	823	384	†	803	335	†	786	299	†	733	203	†
44	812	356	†	790	306	†	773	271	†	716	177	†
45	801	327	†	777	278	†	758	243	†	698	153	†

*Based on life tables for white males and white females in the United States, 1929-1931.

†Under .05 per 1,000.

Gift
Dr. Carl Weller
2-28-1935

Three Thousand Persons Killed Annually in Shooting Accidents

DURING November and December, when the hunting season is at its height, fatal accidental shootings are familiar items in our daily press. It is little realized, however, that year in and year out, about 3,000 persons die in the United States as a result of the careless handling of firearms, not only in hunting, but in or about the home, and on the streets and highways. In this manner, 24 persons out of every million in our population meet death each year. This is nearly twice as many as die by the accidental absorption of poisonous gases of all kinds, whether in homes, by illuminating gas; in garages, by carbon monoxide; or in industry. Traumatism by firearms is sixth in importance as a means of fatal accidental injury, being exceeded only by injuries due to automobiles, falls, burns, drownings and railroad trains or engines.

Because of the greater importance of these other major causes of fatal accidents, too little attention has been given to traumatism by firearms. The statistical picture is extremely interesting, and may help us to reduce this serious loss of life. Adult males, it is found, account for 72 per cent. of the total deaths, while children under 15 years are the victims in no less than 20 per cent. of the deaths. The remaining 8 per cent. occur among adult females. Colored persons have much higher deathrates than white. The deathrate for colored males in the Registration States in 1932 was 7.0 per 100,000, exceeding the white rate of 3.9 per 100,000 by nearly 80 per cent. Males between the ages of 15 and 24 are especially prone to accidental shooting.

The mortality from accidental shooting is notoriously high in the United States. Our deathrate of 2.4 per 100,000 in 1933, for example, compares very unfavorably with the rate of .2 deaths per 100,000 for England and Wales, in 1932. Obviously much of this difference is accounted for by our greater farm population. Possession of guns is comparatively common among farmers and there is therefore greater exposure to this hazard. Our rate is still high, however, when compared with the deathrate in Canada, in which country there is an even larger proportion of farmers.

The highest deathrates from this type of accident occur in the Mountain States of Nevada, Montana, Idaho and Wyoming, the deathrates for these four states in the years 1931–1933 being respectively 7.6, 6.3, 5.9 and 5.4 per 100,000. Two Southern States, Florida and Mississippi, with rates of 5.2 and 5.1 per 100,000, respectively, come next, and then New Mexico, with a rate of 5.0. At the other end of the scale are three New England States—Connecticut, Massachusetts and Rhode Island, and two Middle Atlantic States—New York and New Jersey, with rates varying between

0.5 and 0.8 deaths per 100,000. Average deathrates per 100,000 for the years 1931–1933 from accidental traumatism by firearms are shown in the table below:

It is instructive to note that, in a general way, the geographical picture of traumatism by firearms resembles that for homicides, as given in our STATISTICAL BULLETIN for October, 1933. The highest homicide deathrate for white persons was also found for Nevada. Following in order were New Mexico, Florida, Kentucky, Arizona and Mississippi. The very lowest rates were found in the New England States.

What are the circumstances surrounding these firearm fatalities in the various states? Unfortunately, we do not know. Only one state, Kansas, has published a comprehensive analysis of its firearm fatalities. In that state, which has an average deathrate from this cause, there were 43 accidental shooting deaths in 1933. Out of this total, 21 deaths occurred while persons were on hunting trips; five deaths while a loaded gun was being transported by automobile or wagon; three deaths were the result of accidental injury inflicted during target practice. Fourteen deaths occurred as a result of

Average Deathrates per 100,000 (1931-1933) from Accidental Traumatism by Firearms. By State.

STATE	DEATHRATE PER 100,000	STATE	DEATHRATE PER 100,000
TOTAL U. S.*	2.4	Maine	3.2
		West Virginia	3.0
Nevada	7.6	Minnesota	2.9
Montana	6.3	Missouri	2.9
Idaho	5.9	Nebraska	2.7
Wyoming	5.4	Iowa	2.6
Florida	5.2	Kansas	2.5
Mississippi	5.1	Washington	2.4
New Mexico	5.0	Wisconsin	2.3
Georgia	4.5	Maryland	2.2
Texas	4.4†	North Dakota	2.2
Utah	4.3	Indiana	2.1
Arizona	4.2	California	2.0
Arkansas	4.1	Illinois	2.0
South Carolina	4.1	New Hampshire	2.0
Tennessee	4.1	Delaware	1.9
Kentucky	4.0	Michigan	1.8
Virginia	3.8	Ohio	1.8
South Dakota	3.7	Pennsylvania	1.6
Louisiana	3.6	District of Columbia	.9
North Carolina	3.6	Connecticut	.8
Alabama	3.5	Massachusetts	.8
Oregon	3.5	New York	.8
Oklahoma	3.3	New Jersey	.7
Vermont	3.3	Rhode Island	.5
Colorado	3.2		

*Excluding Texas.
†Rate for 1933 only. Average rate 1931-1933 not available.

accidental gunshot wounds in or about the home. Of these last, three deaths were the result of injuries inflicted by children playing with loaded guns. Other items in the list of home fatalities include two deaths when guns were being taken from racks; two deaths from falls with guns, and one death each from cleaning or dropping a gun.

Insect-Borne Diseases Can Be Eliminated

THE insect-borne diseases constitute an important group of the more definitely preventable diseases of men. Whereas, in the case of other infectious diseases we are, as it were, fighting in the dark against a microscopic foe, the insect-borne diseases present to us a vulnerable point for attack, since the insect carriers are of visible dimensions and can be fought in the open. And, in point of fact, the battle against these diseases has been preeminently successful, even though some human lives have been surrendered in heroic sacrifice to win the victory.

The list of diseases transmitted from person to person by the bite of an insect is fortunately not a very long one. It includes some eight or nine diseases, of which, however, only five are of current interest for us in the United States. These are typhus fever, Rocky Mountain spotted fever, dengue fever, yellow fever, and malaria. The first three of these are relatively rare. In the year 1932 there were 86 deaths from spotted fever, 36 from typhus and 2 from dengue fever within our borders. But yellow fever was once, and malaria still is, for us, a major public health problem. Yellow fever formerly was one of our worst plagues, especially in the Southern States. Today, thanks to the pioneer work and heroic sacrifice of WALTER REED and others, this disease has been reduced, for us, to a medical curiosity. In the stretch of the last 27 years there have been only 2 deaths from this cause in the City of New Orleans, which formerly was a hotbed of yellow fever and where, as late as 1905, an epidemic of this disease claimed no less than 437 lives within a single calendar year.

Malaria, unfortunately, is still a problem of grave dimensions in certain sections of the Union. In 1932, in the Death Registration States (which then included all except Texas), this disease caused a total of 2,540 deaths, of which 62.4 per cent. occurred in the Southern States. Another 32.0 per cent. occurred in four states—Arkansas, Oklahoma, Tennessee, and Missouri. While the remainder of the country had an aggregate deathrate of 0.2 per 100,000 from malaria in 1932, these ten Southern and Southwestern States had an average rate of 8.0. The table on page 6 shows how completely malaria has been eliminated from some sections, and how serious a problem it still presents in others. As is readily noted, 14 states had no deaths from this disease in 1932, 20

had rates of less than 1.0 per 100,000 population, and 4 had rates between 1.0 and 2.0. The malaria problem is concentrated, therefore, in an area of 10 states, including 3 South Atlantic States, 3 in the East South Central region, 3 in the West South Central group, and one West North Central State, Missouri. All of these had deathrates, in 1932, of 2.0 or more per 100,000, and in certain counties of some of them figures ranging from 100 to 150 per 100,000 were registered.

Deathrates per 100,000 from Malaria in the United States Death Registration States, Including District of Columbia, 1932

State	Deathrate per 100,000	State	Deathrate per 100,000
Arkansas	24.4	Nebraska	0.1
Mississippi	19.4	New Jersey	0.1
Florida	16.1	Ohio	0.1
South Carolina	13.4	Oregon	0.1
Georgia	10.8	Pennsylvania	0.1
Louisiana	7.3	Washington	0.1
Alabama	6.7	Iowa	*
Tennessee	5.0	Massachusetts	*
Oklahoma	4.5	Michigan	*
Missouri	3.2	New York	*
North Carolina	1.6	Connecticut	0
New Mexico	1.4	Delaware	0
Kentucky	1.3	District of Columbia	0
Nevada	1.1	Idaho	0
New Hampshire	0.6	Maine	0
Illinois	0.5	Minnesota	0
Kansas	0.4	Montana	0
Indiana	0.3	North Dakota	0
Arizona	0.2	Rhode Island	0
California	0.2	South Dakota	0
Utah	0.2	Vermont	0
Virginia	0.2	West Virginia	0
Colorado	0.1	Wisconsin	0
Maryland	0.1	Wyoming	0

*Less than 0.05 per 100,000 population.

In the 13 states for which we have data classified according to color,† we find that malaria takes a far heavier toll among negroes than among white persons. In fact, in some cases, as, for example, in South Carolina, the negro deathrate from malaria was over four times that of the white people. In Arkansas, where the highest malaria deathrate of the entire country prevails, the negro mortality was more than two and a half times that for the whites; and in Mississippi and Florida, almost twice that for the white population. In view of this high mortality from malaria among negroes, it is naturally found that the states with large proportions of negroes have also high malaria mortality rates for their populations, as a whole.

A historical survey of malaria

†1930 is the latest year for which such figures are available.

mortality is of some interest. In the ten Original Registration States, which did not include any of the Southern or Southwestern States, the deathrate in 1900 was 6.3 per 100,000 population. This indicates that, at that time, malaria was a fairly serious health problem in an area where the mortality is now almost *nil*. By 1923, however, the deathrate had been reduced to 0.1 for these same 10 states, at which very low point it has since remained.

Unfortunately, we have no data for the Southern or Southwestern States dating back as far as 1900. But we have figures for 1917 for North Carolina, South Carolina and Virginia, showing malaria deathrates of 10.9, 34.3, and 5.5, respectively. In 1932, the rates for these same three states were 1.6, 13.4, and 0.2. North Carolina in 16 years has been able to reduce its malaria mortality by 85 per cent. and in Virginia the drop has been 96 per cent.

If every known measure for malaria control were put into effect in the localities where malaria is still prevalent, the deathrate from this disease could be reduced to an almost negligible figure, and malaria as a public health problem would cease to exist in the United States.

Deathrates per 100,000 Population from Malaria by Color in 1930 and the Percentage of Colored in the Total Population, According to the 1930 Census, in Thirteen Selected States

State	Deathrate per 100,000 Population		Percentage of Colored in the Total Population
	White	Colored	
Alabama	8.6	18.9	35.7
Arkansas	25.1	67.7	25.9
Florida	18.8	36.8	29.5
Georgia	10.2	23.7	36.8
Kentucky	1.8	4.9	8.7
Louisiana	6.6	11.3	37.3
Maryland	0.1	0.4	17.0
Mississippi	11.6	22.8	50.4
North Carolina	0.8	3.0	29.5
Oklahoma	4.9	14.2	11.4
South Carolina	8.0	36.6	45.7
Tennessee	4.0	12.3	18.3
Virginia	0.3	1.7	26.9

Results of Modern Treatment of Pernicious Anemia

THE award of the Nobel Prize in medicine to the three American physicians—Doctors GEORGE R. MINOT, WILLIAM P. MURPHY and GEORGE H. WHIPPLE—for their work on pernicious anemia again focuses attention on one of the great contributions of recent American medical science. These workers, it will be remembered, found that this dis-

ease, often fatal hitherto, could be successfully controlled by feeding liver to patients. It is fitting that we now take stock of the effect of their discovery on the trend in the mortality from that disease.

Last year witnessed the lowest deathrate from pernicious anemia among the many millions of Industrial policyholders of the Metropolitan Life Insurance Company since records of this disease first became available in 1921. The standardized deathrate, 2.0 per 100,000 in 1933, was little more than half the figure prevailing in the six years prior to the discovery in 1926 of the usefulness of liver in the treatment of pernicious anemia. Immediately following this discovery the deathrate from the disease declined very rapidly, and in recent years has fluctuated slightly above the minimum level recorded last year. This improvement in the deathrate is all the more remarkable because prior to the discovery of liver therapy the mortality from the disease had been rapidly increasing.

Certain differences in the rates of decline in the deathrate from pernicious anemia are noteworthy. Among white persons, the improvement in mortality has been much greater for females than for males. Formerly, the mortality of females exceeded that of males by over 50 per cent., but in recent years it has been little, if any higher. In both sexes, generally speaking, the younger the age the greater has been the improvement, but substantial decreases have occurred at every age.

The outlook for persons suffering from pernicious anemia is now unquestionably favorable. Notable advances have been made in liver therapy. At first it consisted of the feeding, daily, of raw liver, which was so unpalatable that it was often difficult to keep patients on the necessary regimen. This situation was improved somewhat by the discovery of methods of making a concentrated extract which was administered in daily doses. This extract, however, was rather costly for the ordinary patient. More recently, a very concentrated extract for intramuscular injection has become available. This extract is so potent that injections are needed only once every two to four weeks. This method has also cut down appreciably the cost of treatment of the disease.

Liver treatment of pernicious anemia has done far more than merely prolong the lives of patients. It has restored their health and their ability to work. Persons with the disease may now look forward to a relatively normal life. Death, when it occurs, is now usually due to causes other than pernicious anemia.

In spite of this favorable prognosis, a subsequent increase in the deathrate from pernicious anemia is entirely possible and should not cause alarm. In many respects, the situation is the same as in diabetes. Liver therapy does not cure pernicious anemia. It is a form of "substitution" therapy, replacing an element that the body normally produces. Most patients with pernicious anemia are old or middle-

aged and are subject to the bodily changes characteristic of their age. In a very real sense, then, the result of liver therapy is to postpone death and to transfer the burden of mortality to later ages. Moreover, the number of persons known to be suffering from the disease has increased greatly in the last decade. Several forces have contributed to this result. First of all, the remarkable discoveries of the new Nobel Prize Winners have undoubtedly put physicians more on the alert in the detection of the disease. The frequency of its diagnosis has also been furthered by more exact knowledge of the blood and the mechanism of its formation, as a result of medical research in recent years.

Health Record for October, 1934

WITH five-sixths of the year 1934 elapsed, we find the cumulative deathrate among Metropolitan Industrial policyholders to be 3.9 per cent. higher than that for the same period of last year. This rise in mortality, however, is by no means indicative of an unsatisfactory health situation among these many millions of industrial wage-earners and their dependents; for 1933 was a record year for low mortality. The higher deathrate this year has not extended to insured persons in Canada. Their year-to-date mortality rate is identical with that registered for the January-October period of 1933, namely, 7.2 per 1,000.

The record for the month of October is relatively unfavorable, as is evidenced by a deathrate of 8.3 per 1,000, which is the highest October figure since 1929.

The year has been featured by the absence of serious country-wide epidemics, although there was an outbreak of poliomyelitis in California and other Western States which presented a disturbing situation during the late spring and during the summer months. The mortality from the acute conditions, with the single exception of pneumonia, has been uniformly low. It is difficult to account for the sharp rise in deaths from pneumonia this year; but the fact remains that, from February to September, every month of 1934 recorded a higher pneumonia deathrate than did the like month of 1933. This is just contrary to what is expected during a period featured by a drop of nearly 50 per cent. in the mortality from influenza.

The rise in the deathrate this year from all causes combined has been due, for the most part, to increased mortality from cancer, heart disease and accidents. The great majority of the deaths from cancer and heart disease occur after age 50. The rise in the crude deathrates from these causes may be largely, or even entirely, wiped out when it becomes possible to prepare standardized rates to make allowance for a shift in the age distribution of the insured population. As we have explained in the STATISTICAL BULLETIN earlier this year, much of the increase in

fatal accidents is accounted for by the fact that more persons are now subject to the risks of industry as the result of increased employment. As for automobile fatalities, there is more traffic, both pleasure and commercial, on our streets and highways. This, naturally, increases the accident hazard.

The deathrate in the general population in the large cities of the United States for the month of October was 10.4 per 1,000 estimated population. This may be compared with 9.9 in September and with 10.2 in October, 1933. The diseases which showed increased prevalence during the month of October, as compared with September, were diphtheria, influenza, measles, scarlet fever and smallpox; those which declined in incidence were poliomyelitis and typhoid fever. Comparison with October a year ago shows more sickness in 1934 from measles, poliomyelitis, scarlet fever and smallpox, together with fewer cases of diphtheria, influenza and typhoid fever.

The usual seasonal increase in the incidence of sickness from certain diseases is in evidence. For example, reports from 29 states show 4,793 cases of diptheria in October, as compared with 2,654 in September. Increases were particularly marked in Virginia, West Virginia, Kentucky, Ohio and Indiana. Measles cases, in 22 states, increased from 1,982 to 4,550, with the largest rises in Pennsylvania, Ohio, Virginia, Washington and California. Scarlet fever was approximately twice as prevalent in October as in September, with reported cases in 38 states increasing from 6,559 to 12,386. Wisconsin, Pennsylvania, Indiana, Illinois and West Virginia were the states which showed the largest rises in scarlet fever cases. The current year has been featured by a marked drop in smallpox morbidity, but reports from 46 states show 251 cases in October as compared with 104 in September.

Among the noteworthy items of public health interest reported during October, the following may be mentioned. A ten-day survey of public health facilities in Tacoma, Washington, was completed by DR. CARL E. BUCK, Field Representative of the AMERICAN PUBLIC HEALTH ASSOCIATION. On October 1st, it was reported to the FRENCH ACADEMY OF SCIENCE, by Professor CHARLES NICOLLE, that success had been attained in the use of vaccine against yellow fever. The Bureau of the Census and the FERA, with the cooperation of state vital statistics bureaus, have commenced "Register Your Baby" campaigns in Georgia, West Virginia, Vermont, New Hampshire, Oklahoma, Arkansas, Missouri, Iowa and Kansas. It is expected that each campaign will cover approximately six weeks. The AMERICAN LEGION, in October, adopted a resolution placing the Legion on record as endorsing this campaign and calling on posts and members to lend all possible aid.

The following table shows the mortality among Industrial policyholders for October, 1934, September, 1934, and October, 1933, together with the cumulative rates for the first ten months of each year.

METROPOLITAN LIFE INSURANCE COMPANY

Deathrates per 100,000 for Principal Causes. Weekly Premium-Paying Business in Industrial Department. All Ages (Annual Basis).*

MONTHS OF OCTOBER, 1934; SEPTEMBER, 1934, AND OCTOBER, 1933

CAUSES OF DEATH	ANNUAL RATE PER 100,000 LIVES EXPOSED*				
	Oct. 1934	Sept. 1934	Oct. 1933	Cumulative January-October	
				1934	1933
TOTAL—ALL CAUSES	827.9	715.8	793.7	890.6	857.4
Typhoid fever	2.2	3.2	2.7	1.7	1.6
Measles	.4	.5	.2	3.2	1.6
Scarlet fever	2.2	.9	1.5	2.7	2.6
Whooping cough	2.5	3.2	1.7	3.9	2.4
Diphtheria	3.1	.9	4.0	2.0	2.3
Influenza	5.0	4.2	6.5	11.5	21.4
Tuberculosis (All forms)	60.0	53.9	59.2	62.6	65.5
Tuberculosis of respiratory system	53.1	47.1	53.4	55.0	58.5
Cancer (All forms)	102.0	88.3	96.3	98.8	93.1
Diabetes mellitus	22.4	19.9	22.6	25.1	23.7
Cerebral hemorrhage; apoplexy	58.8	49.0	60.7	65.4	63.3
Diseases of heart†	151.7	128.3	145.9	169.9	160.1
Pneumonia (All forms)	39.9	30.7	40.5	68.8	60.7
Other respiratory diseases	9.1	7.4	10.1	9.8	9.8
Diarrhea and enteritis	20.3	18.0	16.8	12.1	11.0
Chronic nephritis (Bright's disease)	61.0	52.6	61.5	67.5	66.6
Puerperal state—Total	8.3	6.4	7.2	9.3	9.4
Suicides	9.1	8.3	8.8	9.8	10.0
Homicides	7.7	6.1	6.4	6.0	6.0
Accidents—Total	61.2	53.5	54.9	59.7	55.6
Automobile accidents	25.7	20.9	22.7	21.0	19.1
All other diseases and conditions	201.0	180.5	186.0	201.0	190.8

*The rates for 1934 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†Excludes pericarditis, acute endocarditis, acute myocarditis and angina pectoris.

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STATISTICAL BULLETIN,

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DEATHRATES FROM ALL CAUSES

in the Metropolitan Life Insurance Company
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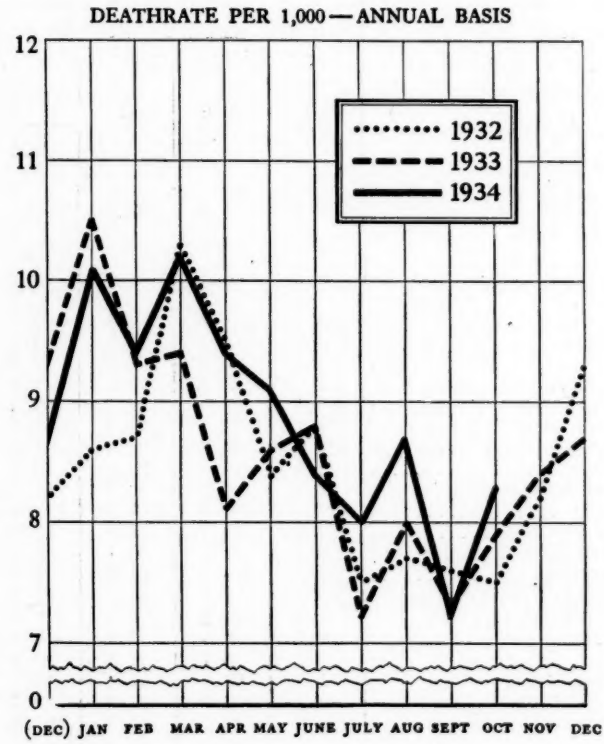

1932	8.6	8.7	10.3	9.5	8.4	8.8	7.5	7.7	7.6	7.5	8.2	9.3
1933	10.5	9.3	9.4	8.1	8.6	8.8	7.2	8.0	7.3	7.9	8.4	8.7
1934*	10.1	9.4	10.2	9.4	9.1	8.4	8.0	8.7	7.2	8.3		

** Rates for 1934 are provisional.*

METROPOLITAN LIFE INSURANCE COMPANY PRESS
NEW YORK, U.S.A.
78358